FACT AND ACTION SHEETS ON HEALTH INEQUITIES

Contents

Background

These fact and action sheets were prepared in the lead up to a visit by Sir Michael Marmot in July 2011, hosted by the New Zealand Medical Association. The purposes of these sheets are several:

- To attempt a brief stocktake on health inequities in New Zealand, both on what the current state of play is and what the future policy priorities might be.
- To provide background material for participants of the Auckland and Wellington symposia.
- To provide material for the media in the lead up to, and during, Sir Marmot's visit.

They are not an exhaustive overview; rather they are a snapshot and 'discussion starter'. To that end, we will be encouraging participants at the symposia to think about what should be the next priorities for addressing health inequities in New Zealand, and contribute their thoughts for improvements to the list of ten next most important actions to reduce health inequalities in Aotearoa New Zealand (page 5 of these fact and action sheets; make comments or suggestions at www.uow.otago.ac.nz/hirp-info.html.)

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Ten facts about health inequalities in Aotearoa New Zealand

1. New Zealand has large ethnic gaps in life expectancy. These increased from a gap of about 7-8 years in the early 1980s to nearly a 10 year gap in the 1990s, but have since closed again to about 7-8 years. [1][2] The long-run trend (the exception of the 1980s-90s emphasised) is for Māori life expectancy to increase faster than non-Māori, with a closing of the gap. For the gap between Māori and non-Māori to close to less than 2 years will require concerted policy attention.

Maori and non-Maori life expectancy

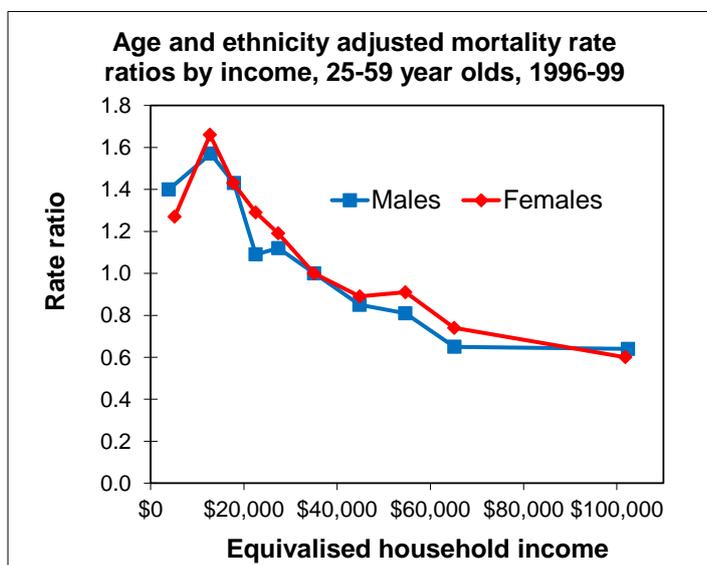Legend: Non-Māori Male, Non-Māori Female, Māori Male, Māori Female
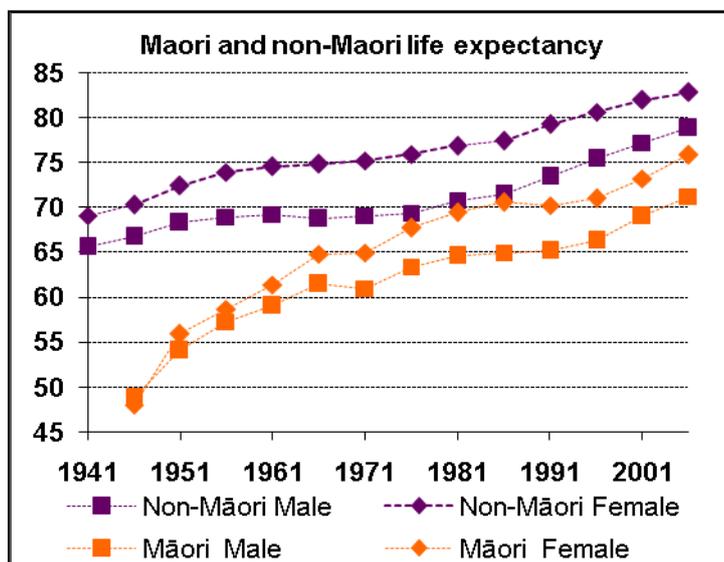
2. Mortality rates for Māori are often two to three times those of non-Māori in middle age, including all causes combined and cardiovascular disease. Pacific rates are intermediary, and Asian rates lower than European/Other (largely due to healthy recent immigrants).[2-4] Differing socioeconomic position between ethnic groups explains about half the ethnic differences in health.[2][5]

3. As in most other countries, there is a gradient of increasing mortality (or worsening health) right across the socio-economic hierarchy, from rich to poor (Figure), most educated to least educated, and affluent to deprived.[6][7] These socioeconomic differences in mortality rates have widened in relative terms up to the year 2000, but have tended to be stable since.[6] A similar pattern of widening gaps in life expectancy by income till about 2000 is also evident.[8] People in the highest third of incomes have a 5-6 year advantage in life expectancy compared to the lowest third. The actual magnitude of socioeconomic inequalities in mortality in New Zealand is about average for rich countries.

Age and ethnicity adjusted mortality rate ratios by income, 25-59 year olds, 1996-99

Rate ratio vs Equivalised household income. Legend: Males, Females

4. Inequalities in health appear very early on in life, and can be seen for most common causes of death, injury or hospitalisation. For example, Māori babies are more than five times more likely to die of Sudden Infant Death Syndrome than non-Māori, and babies living in the most deprived neighbourhoods are six times more likely to be hospitalised with bronchiolitis.

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Public Health Association of NZ Inc / Kāhui Hauora Tūmatanui

Heart Foundation

THE UNIVERSITY OF AUCKLAND — FACULTY OF MEDICAL AND HEALTH SCIENCES — School of Population Health

Runanga Whakapiki Ake i te Hauora o Aotearoa — Health Promotion Forum of New Zealand

5. Child and adolescent health status in New Zealand New Zealand has the highest rate of teenage suicide in the OECD. Binge drinking alcohol, drug use (particularly cannabis) and sexual health issues account for much morbidity.

6. Diabetes rates are higher among deprived and lower income people, and much higher among Māori, Pacific and South Asian people. An increasingly obesogenic environment is an important underlying driver.

7. Suicide rates tend to be highest among young men, Māori, and those living in deprived areas. The prevalence of mental disorder in the past 12 months is higher in younger people and those with lower income, or education or living in more deprived areas. Prevalence of bipolar disorder and substance use disorder are much higher for Māori and Pacific people.

8. Infectious disease hospitalisations and mortality are usually higher for Māori and Pacific people. Rheumatic fever, and inflammatory disease of the heart and other organs following a throat infection, is currently very high by international standards among Pacific and Māori – approximately 50 and 25 times the European/Other rates respectively. Rheumatic fever is associated with crowding and poverty, and is usually rare in rich countries these days.

9. An unequal distribution of social determinants (e.g. income, housing conditions, and employment) is fundamental to driving health inequalities. The graph shows the proportion of dependent children living below 60% of median household income after housing costs from 1996 to 2009. A sharp rise in child poverty occurred
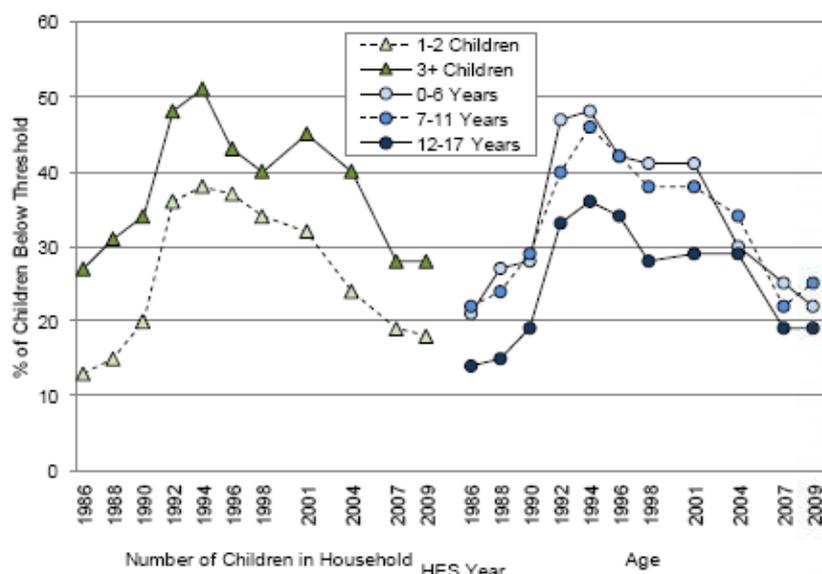
Source: Perry 2010 [185], derived from Statistics New Zealand, Household Economic Survey (HES) 1986-2009

from 1986 to 1994 associated with the 1991 benefit cuts and rising unemployment. Economic conditions and unemployment improved between 1994 and 1998 and child poverty fell. From 1998-2004 rates varied depending on the measure, then with Working for Families child poverty rates fell from 2004-2007.

10. Behavioural risk factors and health services also contribute to health inequalities. Tobacco is particularly important, as is healthy eating. Health services also matter, especially as the effectiveness of treatments and supportive care to both reduce mortality and morbidity become more effective and more numerous.

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Ten things that have been done to address health inequities in Aotearoa New Zealand in recent decades

1. Income inequality reduced slightly in the 2000s following large increases in the Gini in the 1980s-1990s. But is perhaps now increasing again.

2. Social welfare policies have been implemented that in part at least are pro-equity, including Working for Families and (soon) Whanau Ora.

3. Intersectoral activities have been implemented that improve health and health equity have been implemented, e.g. retrofitting and insulation of housing stock (energy efficiency and health benefits) and Before School Check and the National Immunisation register.

Source: Perry 2010 [185], derived from Statistics NZ's Household Economic Survey (HES) 1984-2009

4. Many policies relevant to health include equity goals or purposes, including the Health Strategy, Cancer Control Strategy and – more specifically – Reducing Inequalities in Health Strategy, He Korowai Orange and Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010-2014. This has flowed through into programmes, research, health professional training (e.g. cultural competency), and use of health equity impact tools (e.g. HEAT).

5. Māori health provider, and Māori development more generally, has been a strong feature since at least the 1980s, including the development of Māori health providers and services. The Treaty of Waitangi and Māori health has been enshrined in legislation in the New Zealand Public Health and Disability Act 2000.

6. An increasing focus on the needs of Pacific and other peoples has grown in parallel with New Zealand's increasingly multi-ethnic composition, e.g. growing numbers of Pacific providers.

7. Tailored programmes and health service delivery at the DHB, PHO and other service provider level focusing on Maori, Pacific Island and low socioeconomic people has resulted in increased immunisation rates, improved rates of smoking cessation, cardiovascular risk factor detection and better Type 2 diabetes management.

8. Funding of health services according to deprivation and ethnicity, as markers of need, is operationalized through various funding formulas.

9. Research and monitoring on health inequalities, from the development of deprivation indicators to the linkage of census and health data, by Government analysts to academic researchers, has improved our understanding of health inequalities and allowed tracking of progress. However, this activity is currently reducing.

10. Targets and performance indicators often include metrics by region, ethnicity and deprivation, although Ministry of Health Targets have not been reported by ethnicity or deprivation since 2008-09.
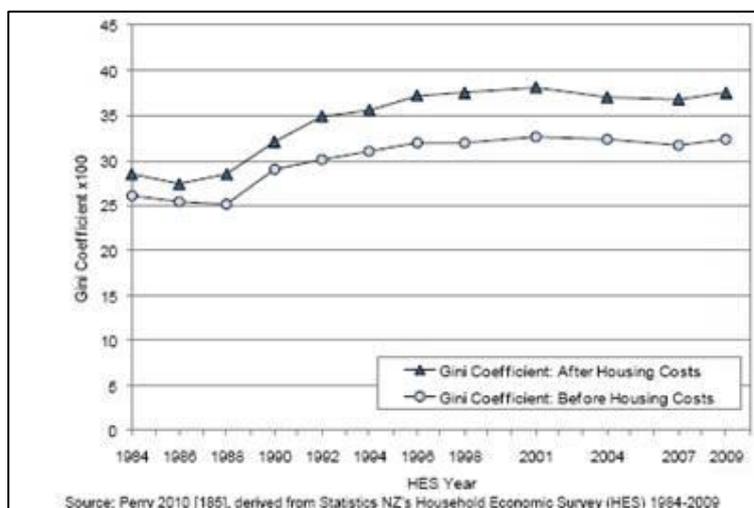
Endorsed by the following organisations:

Ten next most important actions to reduce health inequities in Aotearoa New Zealand

1. <u>Equitable and fair fiscal and social welfare policy</u>, including progressive taxation, comprehensive and fair social policy, and ensuring that everyone has a minimum income for healthy living. Policy needs to be proportionate to need – what is termed proportionate universalism in the Marmot Review [9], or a balance of targeting and universalism.

2. <u>Maintain and enhance social cohesion</u>, through ensuring all services are accessible by all. This requires a whole of government response and far better coordination among every branch of government, from Ministerial level to service delivery.

3. <u>Maintaining and enhancing investment in early childhood,</u> including the need to for there to be a visible leadership that champions child health and wellbeing. Child poverty rates need to be reduced. There needs to be greater coordination among services for children, and a visible cross-party agreement that determines the strategy for improving the environment in which children live.

4. <u>Aligning climate change, sustainability and pro-equity policies</u>, including programmes such as warm and healthy housing in deprived areas to environmental, health and health equity win-wins such as increased walkability of neighbourhoods and financial incentives that both reduce carbon emissions and increase healthy compared to unhealthy food production.

5. <u>Health equity needs to be widely understood.</u> It affects everyone, whether as a prospective parent, employer, employee, political leader or welfare beneficiary. Everybody working in a service delivery occupation needs to be able to alter their practice to reduce health inequities.

6. <u>Ill-health prevention that addresses risk factors contributing to health inequities</u>, including making New Zealand Smokefree by 2025 (as per Parliament's response to Māori Select Committee), encouraging or ensuring healthy food formulation (e.g. salt content in breads and cereals, clear labelling of foods that are healthy and unhealthy, packages of taxes and subsidies to improve healthy eating), and stronger policies to tackle harmful alcohol consumption.

7. <u>Ensuring fair employment and safe and healthy workplaces</u>, extending to include greater access to work for beneficiaries and people with disabilities, a low unemployment rate, and strengthening of occupational health policies.

8. <u>Maintaining and enhancing Māori, Pacific and Asian policies and programmes</u>, including health promotion, screening and health care services models that are culturally specific or tailored.

9. <u>Ensuring health services are equitable</u>, including ensuring a strong equity focus in prioritisation of health resource allocation, quality improvement policies and programmes, and improved information systems. This means, among other things, transparent monitoring, smoothing out regional variations in access, and on-going provider education and support.

10. <u>Health equity research needs to continue and focus on 'what works'</u>, evaluating policies and programmes for equity impacts in processes and (eventually) outcomes such as mental health status and disease incidence.

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Glossary

The difference between health inequity and health inequality

Health inequalities are the observed differences in health status between groups. For example, the difference in lung cancer rates between the rich and poor. Or the difference in melanoma rates between Māori and European/Other.

Not all social group differences or inequalities in health can be called *inequities*. Whitehead (1992) defines health inequities as:

> "… differences which are *unnecessary* and *avoidable*, but in addition are considered *unfair* and *unjust*. So, in order to describe a certain situation as inequitable the *cause* has to be examined and *judged* to be unfair in the *context* of what is going on in the rest of society." [Emphases in original] [10]

This means, for example, that cancer incidence inequalities whose causation we do not understand cannot be classified as inequities. It also implies that judgement is required in determining what is *unnecessary, avoidable, unfair* and *unjust.*

Whitehead identified seven main determinants of health differences:

1. Natural, biological variation.
2. Health-damaging behaviour if freely chosen (e.g. risky sports).
3. Transient health advantage of one group over another, due to one group adopting healthier practises earlier.
4. Health damaging behaviour where the choice of lifestyles is severely limited.
5. Exposure to unhealthy, stressful living and working conditions.
6. Inadequate access to essential health and other public services.
7. Natural selection of health-related social mobility, involving the tendency for sick people to move down the social scale.

The first three do not constitute an inequity, whereas 4 to 6 do when the degree of choice is limited. The issue of 'choice' is central, and is often tied back to a fair distribution of opportunities. For example, a Rawlsian perspective identifies underlying inequities in the distribution of 'primary goods', namely the social determinants of health, power, income, and the social bases of self-respect.[11] However, health equity is not completely determined by underlying social inequality.[12] Further, as some social inequality is often ethically justified due to competing ethical principles, some health inequalities may be a necessary trade-off with other societal goals.[11]

What are the social determinants?

Social factors that influence health are many, and include factors such as income, housing conditions, neighbourhoods, social networks, and so on. The Figure below shows the WHO Commission on Social Determinants of Health framework.[13] Often the unequal (or inequitable) distribution of social determinants in societies gives rise to health inequalities (or inequities). But not always. For example, in New Zealand more deprived neighbourhoods have actually been found

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to live closer to many community resources that one might expect to be associated with better health (e.g. parks, primary health care).[14]

SOCIAL DETERMINANTS OF HEALTH AND HEALTH INEQUITIES
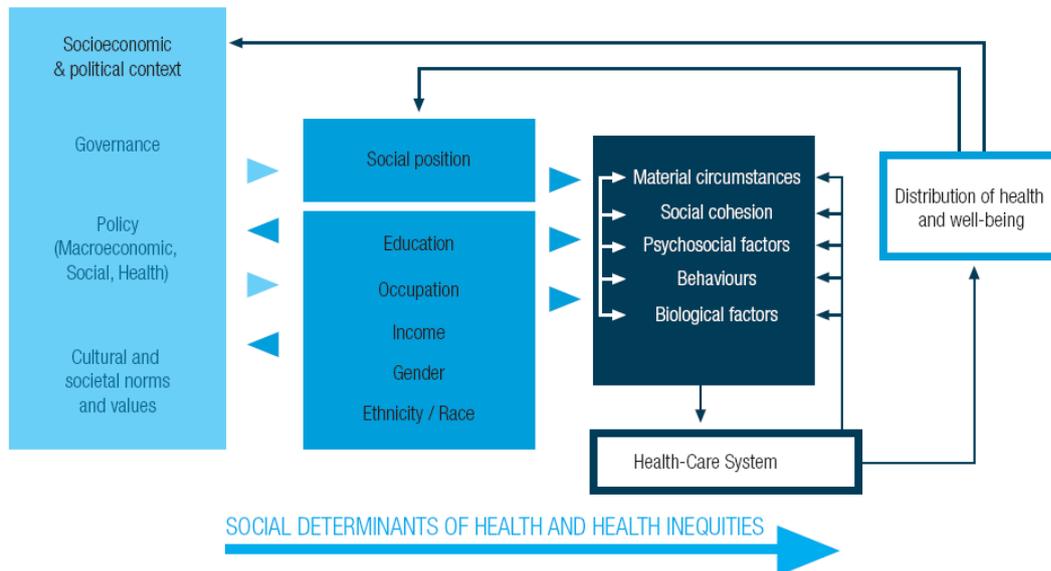
What is the difference in relative versus absolute inequalities?

Comparisons between groups, and over time, should be made with both absolute and relative measures. The graph below shows mortality rates by income in New Zealand. On an absolute scale, inequalities between low and high income have not changed much over time; the rate difference is about 200 per 100,000 for males at each point in time. However, on a relative scale, the rate ratio comparing low to high income has gone up among males from 1.5 in 1981-84 to 1.75 in 2001-04.
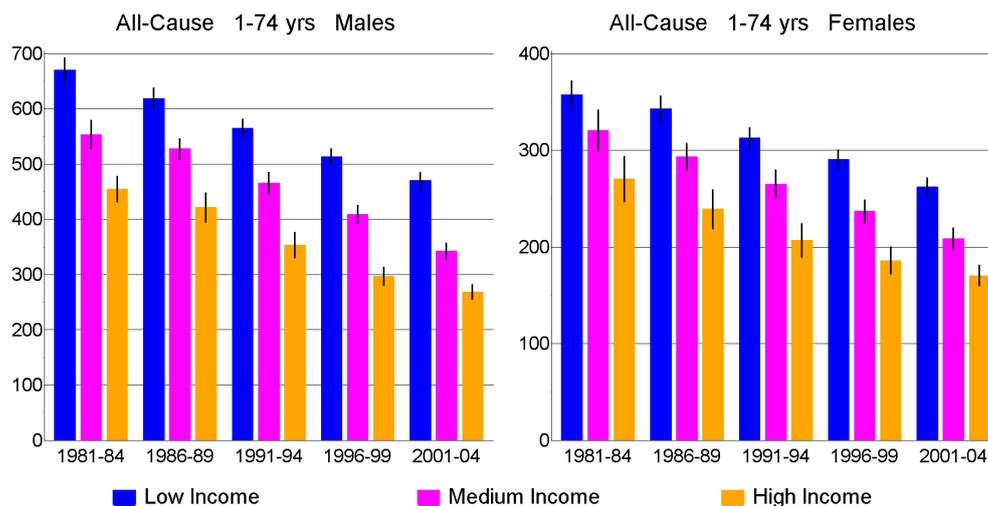
Regarding interventions and changes over time, ideally one wants to see both absolute and relative inequalities decreasing over time or after an intervention. However, it is possible for large reductions in absolute inequalities to occur but relative inequalities to remain unchanged – a partial success, compared to a scenario of both widening absolute and relative inequalities.

Endorsed by the following organisations:

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